

## Request To Copy or Inspect Medical Information

45 C.F.R. §164.524, Wis. Stat. §40.07(2)

(Use this form to request to inspect or copy medical information maintained about you by the Department of Employee Trust Funds (ETF). This type of request is described in ETF's Notice of Privacy Practices located on ETF's Web site at <http://etf.wi.gov>.)

<b>Name</b> (First, MI, Last) Please Print			
<b>Social Security Number</b>		<b>Birthdate</b>	
<b>Current Address</b>			
<b>Telephone Number</b>	(     )	<b>E-mail Address</b> (Optional)	

<b>Scope of Request:</b> (Please fill in an <b>X</b> in the appropriate box below):	
I want a copy of the requested records.	
I want to inspect the requested records.	
I want to both inspect and get a copy of the requested records.	

<b>Description of Records Requested</b> (Please be as specific as possible):	
<b>Period of Request:</b>	
From: _____	To: _____

### Your Right to Copy or Inspect Your Medical Information at ETF:

- You have the right to an answer to your request within 30 days. If the information is not at this location, you have the right to an answer within 60 days. You will be notified in writing if there is a delay beyond 60 days. ETF may request an additional 30 days to process your request.
- Copy fees may be assessed pursuant to ETF's Reproduction Fees Policy.
- Please contact ETF's Privacy Officer toll free at 1-877-533-5020 if you have any questions relating to requests to inspect or copy your medical information contained in ETF's records.

### PARTICIPANT'S SIGNATURE

Date (MM/DD/CCYY)	Signature:

**INFORMATION AND SIGNATURE OF PARTICIPANT'S REPRESENTATIVE (IF APPLICABLE)**

<b>Name of Representative</b> (First, MI, Last)	<i>Please Print</i>		
<b>Relationship to Participant</b>			
<b>Current Address of Personal Representative</b>			
<b>Telephone Number</b>	(     )	<b>E-mail Address</b> (Optional)	

I certify that I am the guardian, conservator, executor, or personal representative of the above-named participant, or hold equivalent status as the participant's legal representative. (APPROPRIATE DOCUMENTATION MUST BE ATTACHED.)

**REPRESENTATIVE'S SIGNATURE**

<b>Date</b> (MM/DD/CCYY)	<b>Signature:</b>
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**FOR ETF USE ONLY**

Approved ☐ \_\_\_\_\_  
Denied ☐ \_\_\_\_\_  
Delayed ☐ \_\_\_\_\_

If delayed, we will act on your request by \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ETF Review Date: \_\_\_\_\_

*This form is available in alternate formats that meet the guidelines for the Americans with Disability Act (ADA).  
Contact ETF toll free at 1-877-533-5020.*